

2/6/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number H044101	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/26/2015
Name of Facility F W HUSTON MEDICAL CENTER	Street Address, City, State, Zip Code 408 DELAWARE ST WINCHESTER, KS 66097	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>S1395</u> Reg. # <u>28-39-163</u> LSC _____	Correction Completed <u>02/26/2015</u>	ID Prefix <u>S3080</u> Reg. # <u>26-41-201 (a) (b)</u> LSC _____	Correction Completed <u>02/26/2015</u>	ID Prefix <u>S3090</u> Reg. # <u>26-41-202 (c)</u> LSC _____	Correction Completed <u>02/26/2015</u>
ID Prefix <u>S3101</u> Reg. # <u>26-41-202 (h)</u> LSC _____	Correction Completed <u>02/26/2015</u>	ID Prefix <u>S3420</u> Reg. # <u>28-39-256</u> LSC _____	Correction Completed <u>02/26/2015</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 1/28/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		